CHILDREN'S DENTAL SPECIALISTS

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Health History Form

For your convenience...
The parent or guardian who accompanies the child is responsible for payment at the time of service.

1 Tell us about your Child

Child's Name _____ (Last / First / MI)

Nick Name: _____ ☐ Male ☐ Female

Siblings that we treat _____

Child's Birthdate ____ / ____ / ____ Child's Age _____

Child's Home # (____) _____

SS# _____

Child's Home Address _____

_____ (Apt / Condo#)

_____ (City / State / Zip)

☐ Biologic Child ☐ Adopted

2 Mother 's Information

Name _____

☐ Stepmother ☐ Guardian Birthdate ____ / ____ / ____

Employer _____

Work # (____) _____ Ext _____

Home # (____) _____

Cellular Phone # (____) _____

SS# _____ DL# _____

3 Father's Information

Name _____

☐ Stepfather ☐ Guardian Birthdate ____ / ____ / ____

Employer _____

Work # (____) _____ Ext _____

Home # (____) _____

Cellular Phone # (____) _____

SS# _____ DL# _____

Parents' Status ☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced

5 Who is Accompanying the Child Today?

Name _____

Relationship _____

Do you have legal custody of this child? ☐ Yes ☐ No

Who may we thank for referring you to our office? _____

_____

6 Person Responsible for Account

Name _____

Relationship _____

Billing Address _____

_____ (City / State / Zip)

Home # (____) _____

Work # (____) _____

Email _____

7 Primary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

_____

Insurance Co. Phone # (____) _____

Group # (Plan, Local or Policy#) _____

Name _____

Address _____

_____

Relationship to Patient _____

Birthdate ____ / ____ / ____

Social Security # _____

Employer _____

_____

8 Dental History

Is this your child's first visit to the dentist? _____

If not, how long since the last visit to the dentist? _____

Were any x-rays taken at previous dental visits?_____

Have there been any injuries to the teeth, face or mouth? _____

If yes, please explain _____

_____

Why did you bring the child to the dentist today/specific concerns?

_____

_____

Does the child have any of the following habits?

Y N Lip Sucking / Biting Y N Nail Biting

Y N Nursing Bottle Habits Y N Thumb / Finger Sucking

Has the child ever had a serious or difficult problem associated with previous dental work? Yes No

If yes, please explain _____

_____

Is the child's water fluoridated? Yes No

Is the child taking fluoride supplements? Yes No

Has the child ever had any pain or tenderness in his/her jaw/joint? (TMJ/TMD)? Yes No

Does the child brush his/her teeth daily? Yes No

Floss his/her teeth daily? Yes No

9 Health History

Has the child ever had any of the following problems?

Y N Handicaps/Disabilities	Y N Hearing/Vision Impairment
Y N Developmental Delay	Y N Bleeding Disorder
Y N Congenital Birth Defects	Y N Diabetes
Y N Hospital Stays/Operations	Y N Shunt
Y N Sleep Apnea/Heavy Snoring	Y N Asthma
Y N ADD/ADHD	Y N Heart Problems/Murmur
Y N Autism	Y N Kidney/Liver Problems
Y N Mental Health Issues	Y N Tuberculosis/Lung Problems
Y N Allergies	Y N Cancer
Y N Allergy to Latex	Y N Hepatitis/HIV/AIDS
Y N Pregnancy	Y N Convulsions/Epilepsy/Fainting

If yes, please explain_____

_____

Please list all drugs the child is currently taking _____

_____

Please list all drugs the child is allergic to _____

_____

Are immunizations up to date? Yes No

Child's Physician _____

Phone # (_____) _____

Is the child currently under the care of a physician? Yes No

We would love to share how great your child is doing with our fans on our Social Media sites and need your approval to do so. Please check the appropriate boxes below with your preferences:

❑ Name and Picture ❑ Picture Only

❑ First name Only and Picture ❑ No Picture or Name

How do you prefer to be contacted for appointment confirmation? Please check all that apply

❑ phone call to #_____

❑ e-mail to _____

❑ text to mobile # _____(charges may apply according to your plan).

10 AUTHORIZATION TO TREAT

I understand that the information I have been given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize Children's Dental Specialists to treat the above mentioned patient using restorative or oral surgery techniques as well as patient management techniques that are reasonable and necessary as the dentists deem advisable. I understand that the treatment plan presented, along with the fees outlined, could change depending upon the time elapsed since the examination and the extent of decay.

_____ _____ _____

Signature of Parent or Guardian Date Relationship to Patient

Office notes: _____

_____